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Against Assisted Suicide — Even a Very Limited Form

YALE KAMISAR*

Professor Robert Sedler is a leading constitutional law professor and a well-known civil liberties lawyer. I think he is right about many things. To cite but one example, I think he was right when he led the ACLU's successful legal attack on certain University of Michigan restrictions on "hate speech."¹ But I cannot agree with him about physician-assisted suicide, no matter how narrowly he frames the issue.²

WHAT IS THE QUESTION?

Professor Sedler did not earn all the civil liberties victories he has won without being a very effective advocate. And as a good advocate he is well aware that, as Justice Frankfurter once said, "[o]n the question you ask depends the answer you get."³ So to get the answer he desires, Sedler frames the issue very narrowly. He speaks only of a "right" or "liberty" to assisted suicide for "*terminally ill* patients" and only for such patients who are "in the *end stages* of their terminal illness."⁴ But is there any principled way to so limit such a right or liberty?

* Clarence Darrow Distinguished University Professor, University of Michigan Law School. A.B. 1950, New York University; LL.B. 1954, Columbia University. This article is an expanded and updated version of a talk delivered at the Symposium on Assisted Suicide and Euthanasia sponsored by the University of Detroit Mercy and held on Nov. 18, 1994. At several places I have drawn freely from my other writings on the subject. I am indebted to University of Michigan law student Marc Spindelman for his valuable comments.

1. See Judge Avern Cohn's opinion in *Doe v. University of Michigan*, 721 F. Supp. 852 (E.D. Mich. 1989). But see generally CATHARINE A. MACKINNON, *ONLY WORDS* (1993). "Hate speech" is a popular name for expression that stigmatizes or victimizes an individual on the basis of race, ethnicity, religion, sexual orientation, or other listed characteristics.

2. See Robert A. Sedler, *Are Absolute Bans on Assisted Suicide Constitutional? I Say No*, 72 U. DET. MERCY L. REV. 725 (1995) (in this issue, preceding this article).

3. See HENRY J. FRIENDLY, *Mr. Justice Frankfurter*, in *BENCHMARKS* 318-19 (1967).

4. Sedler, *supra* note 2, at 725 (emphasis added). Professor Sedler also tells us that the Michigan criminal law prohibiting assisted suicide (a state law that has since expired) was "specifically directed against the terminally ill." *Id.* I think this statement is misleading in two respects.

First of all, the Michigan law was not specifically directed at people who commit suicide without assistance, but at those who purposely *aid another* to commit suicide. The law did not prohibit either suicide or attempted suicide, see MICH. COMP. LAWS. ANN. § 752.1027 (West Supp. 1993), nor, for that matter, does any American criminal law.

Professor Sedler does not want us to think about the impact on our society of establishing a right or liberty to physician-assisted suicide, however limited (at first). He does not want us to think about other situations where the case for assisted suicide may be equally strong. He only wants us to focus on a very narrowly circumscribed set of circumstances.

Why is that? I think it is because, as Sedler and his colleagues are well aware, a severely circumscribed right to assisted suicide would cause less alarm and command more support than a less restricted one. Most of us balk at the notion of actively intervening to promote or to bring about the death of innocent persons. But if only the terminally ill and, still more narrowly, only those in the final stage of their terminal illness, are afforded a right to assisted suicide, we can still manage to reassure ourselves that such a development constitutes only a very, very slight deviation from our social norms.

Thus, a proposal for a rigorously circumscribed right to assisted suicide or a claim that the Constitution protects a very limited right to assisted suicide is quite inviting; one might even say, seductive. And, if I may quote Justice Frankfurter again, "[t]he function of an advocate is . . . to . . . seduce . . ."⁵

On second glance, Professor Sedler's proposal may be even more narrowly circumscribed than I have indicated. Although early in his

However, the fact that there is no form of punishment acceptable for a "completed suicide" and that a criminal prohibition is "singularly inefficacious" to deter attempted suicide:

Does not mean that the criminal law is equally powerless to influence the behavior of those who would aid or induce another to take his own life. Moreover, in principle it would seem that the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request of, the suicide victim.

MODEL PENAL CODE § 210.5 Commentary at 94,100 (Official Draft and Revised Commentaries 1980).

In the second place, the Michigan law was not specifically aimed at the *terminally ill* or those who help the terminally ill commit suicide. The law made it a felony for anyone who knew that another person intended to commit suicide (whether that other person was terminally ill or not, physically disabled or not, seriously ill or not) to "provide the physical means" by which that other person committed suicide or to "participate in a physical act" by which the other person did so. See George Annas, *Physician-Assisted Suicide — Michigan's Temporary Solution*, 328 NEW ENG. J. MED. 1573, 1574 (1993).

If the Michigan anti-assisted suicide law was specifically directed at any group or any person, it was aimed at Dr. Jack Kevorkian. And it is well known that at least some of Kevorkian's patients (including his very first one) were *not* terminally ill, as that condition is usually defined. See *infra* notes 22-23 and accompanying text.

5. FELIX FRANKFURTER, FELIX FRANKFURTER ON THE SUPREME COURT 509, 511 (Philip B. Kurland ed. 1970).

talk, he speaks only of the end stages of terminal illness,⁶ later on he seems to require another factor—unbearable pain and suffering. On two occasions, for example, he asks whether the government can force terminally ill persons to suffer until they have breathed their “last agonizing breath.”⁷

I do not deny that one may imagine situations, or recall actual ones, that constitute very dramatic, very compelling, cases for assisted suicide (or active voluntary euthanasia for that matter). But I do not believe that a narrow exception to the current prohibition against assisted suicide would or could remain a narrow exception for very long. As I shall try to show, I do not believe there is any principled way to limit the right to physician-assisted suicide to the terminally ill even to those suffering unbearable or great physical pain.

More generally, I share the conclusion of the New York State Task Force on the Life and the Law that, although acts of assisted suicide or active euthanasia may be “morally acceptable in exceptional cases,”⁸ such cases cannot justify explicit changes in existing legal or moral rules.⁹

As might be expected, the twenty-four members of the New York Task Force had different views about individual acts of assisted suicide and euthanasia.¹⁰ Some members believed that “assisted suicide is ethically acceptable in certain cases.”¹¹ Nevertheless, these members joined their colleagues in unanimously recommending that existing law should not be changed to permit assisted suicide (or active voluntary euthanasia).¹² Every member of the Task Force concluded that “the potential dangers of this dramatic change in public policy would outweigh any benefit that might be achieved.”¹³

And, reported the Task Force, the dangers of such a change would be the greatest for the elderly, the poor, and the socially disadvantaged:

6. See Sedler, *supra* note 2, at 725, 727, 728.

7. See *id.* at 727, 728.

8. THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 102 (1994) [hereinafter NEW YORK STATE TASK FORCE REPORT].

9. See *id.*

10. The Commission, appointed by Governor Mario Cuomo, was made up of eight medical doctors (two of whom were deans of medical schools), two bioethicists who were not medical doctors, four lawyers, six clergymen (one of whom was also a law professor), the state commissioner of health, the state commissioner on the quality of care for the mentally disabled, and a member of the New York Civil Liberties Union. In addition, three medical doctors and a nurse served as consultants. See *id.* at ii-iii.

11. *Id.* at 120.

12. See *id.*

13. *Id.*

[I]t must be recognized that assisted suicide and euthanasia will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care. Those who will be most vulnerable to abuse, error or indifference are the poor, minorities, and those who are least educated and least empowered. This risk does not reflect a judgment that physicians are more prejudiced or influenced by race and class than the rest of society—only that they are not exempt from the prejudices manifest in other areas of our collective life.¹⁴

* * *

[Many patients] in large, overburdened facilities serving the urban and rural poor . . . will not have the benefit of skilled pain management and comfort care. Indeed, a recent study found that patients treated for cancer at centers that care predominantly for minority individuals were three times more likely to receive inadequate therapy to relieve pain. Many patients will also lack access to psychiatric services. Furthermore, for most patients who are terminally or severely ill, routine psychiatric consultation would be inadequate to diagnose reliably whether the patient is suffering from depression.¹⁵

For similar reasons, not long ago (February, 1992), the ABA House of Delegates rejected a resolution by the Beverly Hills Bar Association that would have supported a California ballot initiative to legalize physician "aid-in-dying." (The "aid-in-dying" label covered *both* physician-assisted suicide *and* physician-administered active voluntary euthanasia.)¹⁶ The opposition to the Beverly Hills resolution was led by John Pickering, the Chair of the ABA Commission on Legal Problems of the Elderly. I think a point Mr. Pickering made on that occasion bears repeating:

[The resolution] calls for "voluntary aid in dying . . . without undue influence or duress. . . ." Before there can be such truly voluntary choice to terminate life, there must be universal access to affordable health care. The lack of access to or the financial burdens of health care hardly permit voluntary

14. *Id.* at 125 (footnote omitted).

15. *Id.* at 143 (footnotes omitted) (citing C. S. Cleeland et al., *Pain and Its Treatment in Outpatients with Metastatic Cancer*, 320 N. ENG. J. MED. 592-96 (1994)).

16. See generally Alexander Morgan Capron, *Proposition 161: What Is at Stake?*, COMMONWEAL, Sept. 1992 (Special Supp.), at 2. The California proposal to legalize "aid-in-dying" (Proposition 161) failed by a 54 percent to 46 percent margin. See Alexander Morgan Capron, *Even in Defeat, Proposition 161 Sounds a Warning*, HASTINGS CENTER REP., Jan. - Feb. 1993, at 32.

choice for many. What may be voluntary in Beverly Hills is not likely to be voluntary in Watts.¹⁷

IF A "RIGHT" OR "LIBERTY" TO PHYSICIAN-ASSISTED SUICIDE
WERE ESTABLISHED, WOULD (COULD) IT BE
LIMITED TO THE "TERMINALLY ILL"?

As I understand it, the basic argument for assisted suicide is "personal autonomy" or "self-determination" or, as Professor Sedler puts it, paraphrasing the language in *Planned Parenthood v. Casey*,¹⁸ "the right to define one's own concept of existence and to make the most basic decisions about bodily integrity."¹⁹ But if one believes that respect for "self-determination" and "personal autonomy" entitles a person to decide for herself whether, when, and how she wishes to end her life, I do not see any principled way in which this right or liberty can be limited to the "terminally ill," let alone persons in the end stage of a terminal illness.

According to Sedler, "[o]bviously, the terminally ill person will not seek to hasten inevitable death until the end stage of the terminal illness has been reached."²⁰ This is not at all obvious to me. It would not surprise me, for example, if someone who learns she has terminal cancer or is HIV positive would seek assistance in ending her life shortly after she heard the bad news. It would surprise me even less if someone in the early stages of Alzheimer's disease, anticipating and fearing mental deterioration some years down the road, would seek

17. Mr. Pickering's arguments in opposition to the Beverly Hills resolution are set forth in a memorandum of January 17, 1992, which is quoted at length in John H. Pickering, *The Continuing Debate over Active Euthanasia*, BIOETHICS BULLETIN (ABA), Summer 1994, at 1, 2.

Shortly after I gave the talk on which this article is based, a conference participant, Dr. Ralph D. Cushing, who treats people with AIDS at Bon Secours Hospital in Grosse Pointe as well as at Detroit Receiving Hospital, expressed the view that there is a "racist" component to the issue of physician-assisted suicide. See Dave Farrell, *Assisted Suicide A Troubling, Divisive Issue for State Doctors*, DETROIT NEWS, Nov. 20, 1994, at 4C (reporting on the conference). According to Dr. Cushing, inner-city patients, many of them poor African-Americans, would be most likely to seek and to obtain physician-assisted suicide, if it were legal. See *id.* Explained Dr. Cushing: "It seems to me that a person with less options for medical care is more likely to fall into despair. And that is when these kinds of decisions are made—when the patient is depressed and believes there is no hope." *Id.*

See also John D. Arras, *The Right to Die on the Slippery Slope*, 8 SOC. THEORY & PRAC. 285, 304 (1982) (predicting that if active voluntary euthanasia were made legal, most dying patients in the middle and upper classes would probably opt for hospice care, but "the poor, who because of their poverty, lack access to mainstream medical care and the amenities of the hospice," would find euthanasia "much more attractive").

18. 505 U.S. 833, 851 (1992). The language about defining one's own concept of existence is discussed *infra* in the text accompanying notes 139-51.

19. Sedler, *supra* note 2, at 728.

20. *Id.* (emphasis added).

assistance in ending her life *before* the disease progressed any further. This, essentially, describes the plight of Janet Adkins, Dr. Kevorkian's first "suicide patient."²¹

But someone in Janet Adkins' situation would not satisfy Professor Sedler's criteria because she would not be "terminally ill" as that term is usually defined; if Adkins had not availed herself of Kevorkian's services, she "might easily have lived for many more years."²² (Terminal illness is commonly defined as a condition that will produce death "imminently" or "within a short time" or in six months or a year.)²³

If there *is* some constitutionally protected right or liberty to decide whether, when and how to end one's life—"to determine the timing of [one's] death"²⁴—surely it would or should apply to someone in Adkins' situation. Why should she have to wait until the final phase of Alzheimer's disease? Does personal autonomy apply to matters of life and death, or doesn't it?

It should be noted that Dr. Timothy Quill, a forceful and eloquent proponent of physician-assisted suicide, would not limit that right to the terminally ill. As he explains, he does not want "to *arbitrarily* exclude persons with incurable, but not imminently terminal, progressive illness."²⁵ But why stop there? Is it any less arbitrary to exclude the quadriplegic? The victim of a paralytic stroke? The mangled survivor of a road accident?

If personal autonomy and the termination of suffering are supposed to be the touchstones for physician-assisted suicide, why exclude those with non-terminal illnesses or disabilities who might have to endure greater pain and suffering *for much longer periods of time* than those who are expected to die in the next few weeks or months? If the terminally ill do have a right to assisted suicide, doesn't someone who must continue to live what *she considers* an intolerable or unac-

21. See JUDITH AHRONHEIM & DORON WEBER, FINAL PASSAGES: POSITIVE CHOICES FOR THE DYING AND THEIR LOVED ONES 14-15, 36, 74 (1992); MICHAEL BETZOLD, APPOINTMENT WITH DOCTOR DEATH 41-46 (1993).

22. AHRONHEIM & WEBER, *supra* note 21, at 74. See also PETER SINGER, RETHINKING LIFE AND DEATH 133 (1995) (Janet Adkins "knew that she might live another ten years or more").

23. See Yale Kamisar, *When Is There a Constitutional "Right to Die"? When Is There No Constitutional "Right to Live?"*, 25 GA. L. REV. 1203, 1210-11 (1991); Thomas Marzen, *"Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 HASTINGS CONST. L.Q. 799, 814 (1994). As pointed out in AHRONHEIM & WEBER, *supra* note 21, at 74, "even by the standards of the Hemlock Society, of which [Adkins] was a member, she was not 'terminal'—defined by the organization as having six months or less to live"

24. Sedler, *supra* note 2, at 728. Professor Sedler further states: "[T]he question is whether [a terminally ill] person will have the choice to hasten inevitable death—to determine the timing of death—or whether that person must continue to suffer until she breathes her last agonizing breath." *Id.*

25. TIMOTHY QUILL, DEATH AND DIGNITY 162 (1993) (emphasis added).

ceptable existence *for many years* have an equal—or even greater—right to assisted suicide?

If a *competent* person comes to the unhappy but firm conclusion that her existence is unbearable and freely, clearly and repeatedly requests assisted suicide, and there *is* a constitutional right to some form of assisted suicide, why should she be prevented from obtaining the assistance of another to end her life just because she does not “qualify” under somebody else’s standards? Isn’t *this* an arbitrary limitation of self-determination and personal autonomy? As Daniel Callahan has observed: “How can self-determination have any limits? [Assuming a person is competent and determined to commit suicide with the assistance of another,] [w]hy are not the person’s desires or motives, whatever they may be, sufficient?”²⁶

There is another reason I very much doubt that if a right to assisted suicide were established for the terminally ill, it could and would remain limited to the terminally ill for very long. As I understand the position of Sedler and other proponents of a right to assisted suicide, one should have the same right to enlist the aid of others to commit suicide as one presently has to refuse or to withdraw life-sustaining medical treatment. Professor Sedler puts it quite strongly. He sees no “principled difference, *in terms of constitutional doctrine and precedent*,” between the alleged right to assisted suicide and the established right to terminate life support.²⁷ (Nor did Barbara Rothstein, Chief Judge of the United States District Court in Seattle, who recently became the first federal judge to strike down, as violative of the Fourteenth Amendment, a state law prohibiting all assisted suicide.)²⁸

But if, as proponents of assisted suicide maintain, there is no significant difference between the right to assisted suicide and the right to reject unwanted life-saving treatment, it is fairly clear that, once established, the right to assisted suicide would not be limited to the terminally ill. For the right of a person to reject life-sustaining medical treatment *has not been so limited*.

One need only recall the *Elizabeth Bouvia* case,²⁹ one of the best known “right to die” cases in this country (probably the third most

26. DANIEL CALLAHAN, *THE TROUBLED DREAM OF LIFE* 107-08 (1993).

27. Sedler, *supra* note 2, at 729 (emphasis in original).

28. *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994). Several months after I gave my talk, Judge Rothstein’s decision was reversed. *See Compassion in Dying*, 49 F.3d 586 (9th Cir. 1995). At one point in his opinion reversing Judge Rothstein, Judge Noonan, who wrote for a 2-1 majority, observed: “At the heart of the district court’s decision appears to be its refusal to distinguish between actions taking life and actions by which life is not supported or ceases to be supported.” *Id.* at 593. As this article went to press, the Ninth Circuit announced that the Chief Judge and ten other members of the Court would rehear the case *en banc*. 62 F.3d 299 (1995).

29. *Bouvia v. Superior Court (Glenchur)*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986).

famous case in its field, behind only the *Quinlan* and *Cruzan* cases).³⁰ At the time of the litigation, Ms. Bouvia, a young woman afflicted with severe cerebral palsy, had a long life expectancy. Nor was she unconscious or mentally impaired. Indeed, the court described her as both "intelligent" and "alert."³¹ Nevertheless, she was granted the relief she sought—the right to remove a nasogastric tube keeping her alive against her wishes.

To be sure, neither the *Bouvia* case nor other cases upholding the right of non-terminally ill persons to reject life-saving treatment³² were decided by the United States Supreme Court. But *Bouvia* and these other cases have been well received by bioethicists and medico-legal commentators. As Professor John Regan pointed out at this symposium, the highest court of New York and courts across the land have come to recognize that patients have "a virtually absolute right to refuse life-sustaining treatment, so long as they are competent in making that choice."³³

In an effort to draw a bright line between the terminally ill and all others who might seek help in committing suicide, Professor Sedler contends that the state "cannot assert any conceivably valid interest"³⁴ in requiring a terminally ill person to wait until death comes naturally because "*there can be no valid interest in 'preserving life' when there is no 'life left to preserve,'*"³⁵ and "*for the terminally ill there is no life left to preserve.*"³⁶ I must say I do not understand this argument.

A terminally ill person, for example, a cancer patient who, despite our best medical efforts, is likely to die in a number of months, is still a "person" or a "human being." Moreover, a terminally ill patient's mental powers can hardly be greatly impaired if she retains the

30. See *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990); *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

31. See *Bouvia*, 225 Cal. Rptr. at 300, 305.

32. See *Fosmire v. Nicoleau*, 75 N.Y.2d 218 (N.Y. 1990); *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990); *State v. McAfee*, 385 S.E.2d 651 (Ga. 1989); *Thor v. Superior Court (Andrews)*, 855 P.2d 375 (Cal. 1993). *Fosmire* sustained the right of a patient to refuse blood transfusions following a Cesarean delivery despite the fact the patient was responsible for the care of her infant. *McKay and McAfee* involved respirator-dependent quadriplegics who apparently had long life expectancies. *Thor* involved a state prison inmate, rendered quadriplegic as a result of a fall while in prison, who refused to consent to medication or artificial feeding.

33. See remarks of John J. Regan at the University of Detroit Mercy Symposium on Assisted Suicide and Euthanasia, November 18, 1994 (on file with the *University of Detroit Mercy Law Review*). See also 1 ALAN MEISEL, *THE RIGHT TO DIE* 470 (2d ed. 1995) (study of "new generation of right-to-refuse-treatment cases . . . leads to the conclusion that the right of a competent person to refuse medical treatment is virtually absolute").

34. Sedler, *supra* note 2, at 729.

35. Robert A. Sedler, *The Constitution and Hastening Inevitable Death*, 23 HASTINGS CENTER REP., Sept. - Oct. 1993, at 20, 24 (emphasis in original).

36. Sedler, *supra* note 2, at 730.

decision-making capacity necessary to invoke the right to assisted suicide. (For the present, at least, proponents of assisted suicide are not contending that *incompetent* persons should be entitled to enlist the assistance of others in committing suicide.) Thus, if a right to assisted suicide for the terminally ill were established, an individual could only exercise such a right if she were capable of making a voluntary and informed choice. How can it be said that such a person has "no life left to preserve"?

To be sure, a terminally ill person may *feel* or honestly *believe* that what is left of her life is not a "life" worth preserving. But so too may many others suffering from serious illnesses or disabilities, who are not terminally ill.

A person paralyzed from the neck down may forcefully argue that, although she has a long life expectancy, she has less "life" to live than a terminally ill person who, though seriously ill, is still better able to function in society in the months she has left. The same argument may be plausibly made by a multiple sclerosis patient who, though *not* terminally ill, is so debilitated by her illness that she cannot move from her nursing home bed or eat or perform bodily functions without the assistance of others. Indeed, very recently, Professor Sedler discussed the constitutional status of the multiple sclerosis patient described above (I simply reproduced his description) and concluded that she, as well as a terminally ill person, had a constitutional right to suicide.³⁷

At this symposium Professor Sedler has painted a bright line between the terminally ill and all others who seek assistance in committing suicide. But less than a year earlier he grouped together the terminally ill *and* those who, though they "may live for some additional years,"³⁸ are "so physically debilitated that for them life has become unendurable,"³⁹ maintaining that those falling into *either* category should have a constitutional right to obtain the assistance they need to end their lives by suicide.⁴⁰

Is it any wonder that I do not believe that a right to assisted suicide for the terminally ill will be confined to the terminally ill for very long?

37. See Robert A. Sedler, *Constitutional Challenges to Bans on "Assisted Suicide": The View from Without and Within*, 21 HASTINGS CONST. L.Q. 777, 791-93 (1994).

38. *Id.* at 792.

39. *Id.* at 793, 795. See also *id.* at 797.

40. See *id.* at 795: "[W]here it matters, bans on assisted suicide should be held to be unconstitutional. These bans matter for people who are terminally ill and for people who are so physically debilitated that for them life has become unendurable."

CAN (SHOULD) THE RIGHT TO ASSISTED SUICIDE BE
LIMITED TO THOSE UNDERGOING GREAT "PAIN
AND SUFFERING"?

Although Professor Sedler's position on the issue is not perfectly clear, a restriction frequently placed on the right to assisted suicide is that the person asserting this right must be experiencing great "pain and suffering" (two classifications commonly lumped together, but hardly identical).

If this restriction means great physical pain, very, very few people *should* qualify for assisted suicide. Although pain is notoriously under-treated in this country,⁴¹ "according to experts in the field of pain control, almost all terminally ill patients can experience adequate relief with currently available treatments."⁴² Thus, the Memorial Sloan-Kettering Cancer Center's Kathleen Foley, a well-known expert on pain control, reports that suicidal ideation and suicide requests "commonly . . . dissolve with adequate control of pain and other symptoms."⁴³

If the "pain and suffering" restriction means "suffering" (including "psychological suffering"), not physical pain, we are no longer talking about a relatively small, easily identifiable group. Physicians can and should relieve physical pain, but "suffering" is a more complex matter: "When euthanasia [or assisted suicide] is requested, the doctor is being asked to act upon someone else's subjective suffering—variable from person to person, externally unverifiable, and always, in principle, reversible"⁴⁴

41. See AHRONHEIM & WEBER, *supra* note 21, at 99-114.

42. *Id.* at 102.

43. Kathleen Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, J. PAIN & SYMPTOM MGMT. 289, 290 (1991). Adds Dr. Foley, "The high cost of pumps, drugs, and home care supervision on a 24-hr basis makes [pain control] only available to a limited number of patients who have appropriate health care coverage. By rationing pain management on a financial basis, patients are being forced to consider death as their only option." *Id.* at 292.

As Lord Goff of Chieveley recently recalled, when Dame Ciceley Saunders, founder of the modern hospice movement, took the head of the British "Voluntary Euthanasia Society round the hospice and explained her work to him", he wrote to her afterwards that "'there would be little or no problem of euthanasia if all the terminal disease folk could end their lives in that atmosphere you have done so much to create—but alas that can hardly be for many a long year.'" Robert Goff, *A Matter of Life and Death*, 3 MED. L. REV. 1, 18 (1995), (quoting SHIRLEY DU BOULAY, CICELEY SAUNDERS 180 (rev. ed. 1994)).

44. CALLAHAN, *supra* note 26, at 102. See also Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, — U. RICH. L. REV. (forthcoming 1995):

No evidence could establish that a patient is not suffering the severe and unrelenting suffering he claims, or which the doctor subsequently claims the patient claimed. . . . Repeated requests for PAS [physician-assisted suicide] do not prove suffering so much as they prove determination, and exactly this

If a right to assisted suicide were established, how could this right be denied an otherwise eligible person who *says*, indeed *insists*, that her "externally unverifiable" suffering is intolerable? As a practical matter, would we not defer to the patient's own assessment of her suffering? As a matter of principle, shouldn't we?

So long as a person is competent and her desire to enlist the aid of others in dying by suicide firm and persistent, why should her "right" to end her life in the manner she chooses (if such a right exists) be denied because her suffering does not satisfy someone else's standard?

If and when a right to assisted suicide is established, any requirement that the patient experience "unbearable" or "intolerable" suffering (or "pain and suffering") will probably turn on the patient's own view of her suffering—or drop out entirely.⁴⁵

WILL THE FINE LINE BETWEEN ASSISTED SUICIDE AND ACTIVE VOLUNTARY EUTHANASIA ENDURE FOR VERY LONG?

How does active voluntary euthanasia differ from assisted suicide? Active voluntary euthanasia occurs when someone other than the person who is to die performs the last act—the one that actually brings about death. Assisted suicide takes place when another person provides assistance (for example, provides the physical means to commit suicide), but the person whose life is to be ended performs the last, death-causing act herself. "Recent [court] decisions draw a distinction between active participation in a suicide [murder] and involvement in the events leading up to the suicide, such as providing the means [assisted suicide]."⁴⁶

Because assisted suicide is less widely condemned by the criminal law and the fact that the final act is in the patient's hands is seen as

kind of determination would well serve to make *prima facie* plausible claims that comfort care has failed—and there would be no way, in the face of a patient's insistence that it had failed, to prove it had not.

45. Cf. Albert Jonsen, *To Help the Dying Die — A New Duty for Anesthesiologists?*, 78 ANESTHESIOLOGY 225, 227 (1993):

[F]ear of uncontrolled pain [and, I would add, "unbearable suffering"] is no longer a major feature of the justifying arguments [for "aid-in-dying"]. Autonomy, not pain or its merciful alleviation, is the principal and even sole justifying argument offered by modern proponents.

46. *People v. Kevorkian*, 527 N.W.2d 714, 736 (Mich. 1994), *cert. denied*, 115 S. Ct. 714 (1995). The *Kevorkian* majority discusses, and seems to agree with, two cases from other jurisdictions where the courts found the defendant guilty of murder (which is how American criminal circles currently view active voluntary euthanasia) not assisted suicide: *People v. Cleaves*, 280 Cal. Rptr. 146 (Cal. Ct. App. 1991) (defendant held decedent down to keep him from falling off bed while decedent completed an act of self-strangulation); *States v. Sexson*, 869 P.2d 301 (N.M. Ct. App. 1994) (defendant held rifle in position while wife pulled trigger of rifle that killed her).

offering more protection against potential abuse,⁴⁷ assisted suicide causes less alarm than active euthanasia and generally commands more support. But I think the two practices are much more alike than they are different—both involve the active intervention of another to promote or to bring about death.

As I have spelled out in some detail elsewhere,⁴⁸ one who looks at the media's treatment of the legal and ethical problems raised by the so-called right to die, or even the medico-legal literature on the same subject, quickly discovers that the line between assisted suicide and active voluntary euthanasia is often blurred and sometimes obliterated. Moreover, the emergence of such phrases as "aid-in-dying" and "physician-assisted death," terms which cover *both* assisted suicide and active euthanasia,⁴⁹ have further smudged the distinction between the two practices.

While the distinction is hard to maintain in practice⁵⁰ it is even harder to defend as a matter of principle. If a person who resolves to

47. See Herbert Hendin, *Selling Death and Dignity*, 25 HASTINGS CENTER REP., May - June 1995, at 19.

48. See Yale Kamisar, *Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia*, in EUTHANASIA EXAMINED 225, 230-33 (John Keown ed., 1995); Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, 23 HASTINGS CENTER REP., May - June 1993, at 32.

49. See authorities cited *supra* note 16 and accompanying text; *infra* text accompanying note 55; see also Timothy E. Quill, *The Care of Last Resort*, N.Y. TIMES, July 23, 1994, at 15A (repeated use of the term "physician-assisted death").

50. Consider the following: A competent patient who has resolved to die by suicide and made her wish clear accomplishes her purpose by swallowing a lethal dose of medication which her physician has placed (a) on the night stand next to her bed, (b) in her hand, (c) in her mouth. Has the physician committed murder (which is how active voluntary euthanasia is currently regarded) or has she assisted in a patient's suicide? Compare Lawrence O. Gostin, *Drawing a Line Between Killing and Letting Die: The Law, and Law Reform, on Medically Assisted Dying*, 21 J.L. MED. & ETHICS 94, 96 (1993) with Kamisar, *Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia*, *supra* note 48, at 230-31.

It may be argued that when a physician puts a lethal dose of medication in a patient's hand he is actively participating in an act that directly causes death. On the other hand, it may be argued that when a physician puts the means of committing suicide in a patient's hand, the lethal process has not yet become irreversible; the patient can still change her mind and put the medication on her night stand or throw it away instead of placing it in her mouth. However it comes out, the line between (a) putting a lethal dose of medication in a patient's hand and (b) putting it on top of her pillow or on her night table seems excruciatingly thin.

I think placing a lethal dose of medication in a person's mouth at her request would strike many people as a clear case of active voluntary euthanasia. But suppose a physician tells her patient: "I am going to place some lethal medication in your mouth, but don't be in a hurry to swallow it. You still have a choice. It's your life. I'm going to leave the room. If you decide that when all is said and done you do not want to die by suicide, that is your right. Simply remove the substance from your mouth or, if you prefer, spit it out." Suppose further that, after the physician leaves the room, the patient swallows the medication. It is not at all clear to me that this is active voluntary euthanasia rather than assisted suicide.

end her life, but is unable to do so without another's help, is entitled under certain circumstances to the assistance of another in bringing about her own death, what about the person who is similarly determined to end her life but *unable* to perform the last, death-causing act herself? Why should she be denied the assistance of another in carrying out the final act; i.e., denied active euthanasia?

If the claim that one has, or ought to have, a right to control the time and manner of one's death is well founded—if one who is terminally ill has, or ought to have, the right to make the choice whether or not to go on living until death comes naturally—how can this right be denied to someone simply because she cannot swallow the barbiturates that will bring about death?

Physician-assisted suicide may be less alarming than physician-administered active euthanasia and may be regarded as a lesser deviation from our social norms, but once we cross the line between the rejection of life-sustaining medical treatment and the active intervention of another to promote or to bring about death, I do not see how we could (or why we would) stop short of active voluntary euthanasia.

Until recently, Dr. Timothy Quill and Dr. Diane Meier would have disagreed with me. In 1992 they announced their support for physician-assisted suicide (under certain conditions), but balked at active voluntary euthanasia.⁵¹ Although Quill and Meier recognized that excluding active voluntary euthanasia from "a continuum of options for comfort care" occurs at "a cost to competent, incurably ill patients who cannot swallow or move, and who therefore cannot be helped to die by assisted suicide,"⁵² they opposed legalizing any form of active euthanasia "because of the risk of abuse it presents."⁵³ Access

51. See Timothy E. Quill, et al., *Sounding Board: Care of the Hopelessly Ill — Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENG. J. MED. 1380 (1992); see also Quill, *supra* note 25, at 155-67. As Dr. Quill points out, much of the 1992 article he co-authored is reproduced in chapter eight of his 1993 book. *Id.* at 155.

52. Quill et al., *supra* note 51, at 1381.

53. *Id.* According to Dr. Quill and his co-authors, because in assisted suicide "the final act is solely the patient's," and thus "the risk of subtle coercion from doctors, family members, institutions, or other social forces is greatly reduced," the "balance of power between doctor and patient is more nearly equal in physician-assisted suicide than in euthanasia." *Id.* But see Callahan & White, *supra* note 44:

Notably, arguments of [the kind made by Dr. Quill and his co-authors] do not cite any empirical studies to show there is less coercion and a greater balance of power. There are no such studies. The claim is pure assertion, and not a very plausible one at that. To insinuate the idea of suicide into the mind of someone already grievously suffering can surely be no more difficult than insinuating the idea of euthanasia; indeed, it could be all the more manipulative if the insinuated hint was combined with a tacit flattery of someone's capacity to act on his or her own.

As for the power of doctors, their general prestige as professionals who by training and experience are widely thought better to understand matters of life and death than the rest of us, and their capacity to give or withhold

to medical care in this country, they pointed out "is currently too inequitable, and many doctor-patient relationships too impersonal, for us to tolerate the risks of permitting active voluntary euthanasia."⁵⁴

When I first read these comments by Quill and Meier, my reaction was: Why can't the very same thing be said about not tolerating the risks of permitting *assisted suicide*? Shouldn't we either legalize both assisted and active euthanasia or *continue to prohibit* both?

On reading the comments Quill and Meier made in 1992, it also struck me that their approach to euthanasia was not very different from mine. When it came to assisted suicide, they were what might be called "act utilitarians" and I was what might be called a "rule utilitarian" (one who does not believe that the beneficial consequences of individual acts are decisive when one makes public policy). But when it came to euthanasia, *all of us*, it seemed, were inclined to be "rule utilitarians."

That was 1992. Two years later, Drs. Quill and Meier took a decidedly more "act utilitarian" approach. They no longer defended an absolute prohibition against active euthanasia. Along with four others, they co-authored an article endorsing what they euphemistically called "physician-assisted death," a term not limited to assisted suicide. Under certain circumstances, they now maintained, individuals should be entitled to obtain active voluntary euthanasia as well:

To confine legalized physician-assisted death to assisted suicide unfairly discriminates against patients with unbelievable suffering who resolve to end their lives but are physically unable to do so. The method chosen is less important than the careful assessment that precedes assisted death.⁵⁵

Quill and Meier were not the only well-known commentators in the field to shift their position on euthanasia. In 1993 Lawrence Gostin, then the Executive Director of the American Society of Law, Medicine and Ethics (and now a member of the Georgetown Law Center faculty), proposed decriminalizing assisted suicide under certain conditions, but not active euthanasia under any circumstances (evidently because he respected the bright line between active killing

lethal drugs, already establishes the power differential between themselves and their patients.

In any event, the view held by Quill and Meier in 1992 that the "balance of power" between physician and patient was more nearly equal in assisted suicide than in euthanasia did not keep them from crossing the line between assisted suicide and euthanasia two years later. See *infra* note 55 and accompanying text.

54. Quill et al., *supra* note 51, at 1381.

55. Franklin G. Miller et al., *Sounding Board: Regulating Physician-Assisted Death*, 331 NEW ENG. J. MED 119, 120 (1994).

and "letting die.")⁵⁶ A year later, however, Gostin signed the same article Doctors Quill and Meier did, concluding that the legalization of "physician-assisted death" could not be limited to those patients who possessed the capacity to carry out the final act themselves.⁵⁷

The fact that several participants in the debate on death and dying drew a distinct line between assisted suicide and active euthanasia only to ignore that line within the span of a few years is further evidence, I think, that the distinction between physician-assisted suicide and physician-administered active voluntary euthanasia is too thin a line to endure for very long.

LIBERALS, CONSERVATIVES AND "SLIPPERY SLOPE" ARGUMENTS

Professor Sedler wants us, and wants the courts, to focus on a specific and narrow question: Do terminally ill patients have a right to physician-assisted suicide? He does not want us, or the courts, to consider the impact, if any, of an affirmative answer on "our views about death and dying or the sanctity of life."⁵⁸ He assures us that "we need not worry about any 'slippery slope'".⁵⁹

Professor Sedler has made the point before. Indeed, he has gone so far as to say that the kind of "slippery slope" arguments I have made in the course of defending the absolute prohibition against assisted suicide have "no place" in constitutional litigation and cannot be utilized "to avoid" grappling with the specific and narrow question he and his colleagues have framed.⁶⁰

I must disagree. I do not believe a court can *responsibly* resolve the constitutional issue Sedler and others have presented *without* considering the general implications of the asserted right. Surely a judge should not put on blinders and forge straight ahead without thinking about the impact of her holding (however, "narrow" and "specific" it may seem at first glance). Surely she should not "buy" an advocate's argument without thinking hard about what it is she is really "buying."

I share the view that a court should rest its judgment on a principle of general significance that produces like results in like cases.⁶¹ If so, how can a judge avoid considering what *other* fact situations not presently before the court are (or are not) like cases?

Suppose a right to physician-assisted suicide for the terminally ill *were* established. Is there any doubt that lawyers would soon appear in

56. See Gostin, *supra* note 50, at 98. "There remains almost universal agreement in law and medicine," observed Gostin, "that letting die is ethical, while killing is not. No such agreement exists on physician assisted suicide." *Id.*

57. See Miller et al., *supra* note 55, at 120.

58. Sedler, *supra* note 2, at 726.

59. *Id.* at 727.

60. See Sedler, *supra* note 35, at 20, 23.

61. See generally Herbert Wechsler, *Toward Neutral Principles of Constitutional Law*, 73 HARV. L. REV. 1 (1959).

court arguing that (a) the new right could not be limited to the terminally ill, but had to apply as well to others who would experience unacceptable suffering for many years; and that (b) the new right could not be limited to assisted suicide, but had to include active euthanasia, at least for those severely ill patients who were unable to perform the "final act" themselves? If it is appropriate to transcend the "narrow" and "specific" issue presented in a case *once* it is decided, and to start building immediately on its implications, why is it improper to *anticipate* the implications of a *soon-to-be-decided* case and call the court's attention to them?

I am well aware that a court must decide the case before it and not some other one. But as Justice Felix Frankfurter has observed—that does not mean that a case is dissociated from the past and unrelated to the future. We must decide this case with due regard for what went before and no less regard for what may come after.⁶²

It is plain that proponents of assisted suicide (and active voluntary euthanasia) consider themselves the "liberals" or "civil libertarians" in this debate. In light of this, I find their disdain for the "slippery slope" argument somewhat unbecoming. For in other settings, "liberals" have been quick to make similar "slippery slope" arguments.

As the author of the leading law review article on "slippery slopes" has pointed out, such arguments appear frequently in discussions about freedom of speech and the rights of those suspected of crime.⁶³ I have little doubt, for example, that Professor Sedler and many other "liberals" defended the Nazis' right to march to Skokie largely because they feared that denying them First Amendment protection might start us down a slippery slope—that "if the swastika and burning crosses are banned today on good grounds, relatively innocuous symbols may be banned tomorrow on not so good grounds."⁶⁴

The *Skokie* case may be viewed as a controversy between "act utilitarians," who wanted to focus on the particular facts of the case, and "rule utilitarians," who preferred to dwell on the long-range implications for the First Amendment of denying the Nazis the right to march. But this time it was clear that the "liberals" were the rule utilitarians.

Only a day before this symposium was held, the *New York Times* reported that a series of killings by terrorists had prompted the Israeli government to authorize harsher interrogation of suspected Muslim

62. *West Virginia State Bd. v. Barnette*, 319 U.S. 624, 660-61 (1943) (Frankfurter, J., dissenting).

63. See Frederick Schauer, *Slippery Slopes*, 99 HARV. L. REV. 361 (1985).

64. JOEL FEINBERG, *OFFENSE TO OTHERS* 92-93 (1985); see also Schauer, *supra* note 63, at 363.

militants and that this decision had aroused the ire of various human-rights groups.⁶⁵ The Israeli government supported its position by pointing to dramatic individual cases. It made what has been called the “ticking bomb” argument—underscoring the need to resort to torture to extract information that could prevent imminent killings.⁶⁶ But a goodly number of Israeli “liberals” were unpersuaded that a very few dramatic cases justified an exception to the absolute ban against torture. They feared that once a crack appeared in the flat prohibition against torture, the crack would gradually widen. Most interrogation situations, they emphasized, were “a far cry” from the “ticking bomb” case.⁶⁷ This controversy, too, may be viewed as one between “act utilitarians” and “rule utilitarians.” And once again the “rule utilitarians”—those making the slippery slope argument—were the “liberals.”⁶⁸

I am well aware that, as Sissela Bok observed a quarter-century ago, “slippery slope” or, as they are often called, “thin edge of the wedge” arguments have been “used so often and for such dubious purposes that they tend to be brushed aside as merely rhetorical.”⁶⁹ But, added Professor Bok, if these arguments are seen as “expressions of caution in the face of unknown future changes, there must be times when the caution has turned out to be justified.”⁷⁰ The overuse or misuse of the slippery slope or wedge argument on some occasions does not justify its dismissal in other settings. Whenever such arguments are deployed, “it will be necessary to test the reasonableness of such a use within the context of the specific conflict.”⁷¹

65. Joel Greenberg, *Israel Permits Harsher Interrogation of Militants*, N.Y. TIMES, Nov. 17, 1994, at A6.

66. *See id.*

67. *See id.*

68. One might argue that if a “ticking bomb” case actually arose, the legal system would somehow allow torture through the use of some subterfuge. Even so, it does not follow that the “absolute prohibition” against torture should be repealed. It is much easier to justify torture if one approaches the problem generally by balancing the “interest” in banning torture against the “interest” in peace and order. On the other hand, by refusing to acknowledge that we should balance the costs and benefits of torture as a general matter, we strengthen the presumption against torture and increase the likelihood that it will only be resorted to in the rarest and most compelling situations. See the discussion in GUIDO CALABRESI, *IDEALS, BELIEFS, ATTITUDES, AND THE LAW* 167 n.240 (1985) and Charles L. Black, Jr., *Mr. Justice Black, the Supreme Court, and the Bill of Rights*, HARPER’S MAG., Feb. 1961, at 63, 67-68. Both commentators discuss how we should go about deciding whether the police may torture a prisoner to get him to reveal the location of a nuclear bomb when the police knew he has hidden the bomb somewhere in a major city and the bomb is due to explode in a very short time.

69. Sissela Bok, *The Leading Edge of the Wedge*, HASTINGS CENTER REP., Dec. 1971, at 9.

70. *Id.*

71. *Id.*

I submit that the experience in the Netherlands suggests that the use of the "slippery slope" argument is reasonable in the context of assisted suicide and active euthanasia.

A survey commissioned by the Dutch government revealed that in 1990 (the year covered by the survey) there were 1,000 cases of active, intentional termination of life without an explicit request from the patient (nonvoluntary euthanasia).⁷² As would be the case in the United States if current proposals were put into effect, the Dutch guidelines for assisted suicide and active euthanasia "are dependent upon the willingness of doctors to report what they do."⁷³ But "it is evident that most do not, and certainly not those substantial numbers who engage in nonvoluntary euthanasia."⁷⁴

Recently, in the Assen case (a case referred to by the name of the city where it was tried), the Dutch Supreme Court extended the nation's toleration for assisted suicide and euthanasia to patients who are suffering psychological distress, but not physical (let alone terminal) illness.⁷⁵ As Professor Herbert Hendin, the Executive Director of the American Suicide Foundation, and a close observer of the Dutch scene, has recently pointed out:

[T]he Assen case seemed to justify the concerns here as in the Netherlands of a "slippery slope" that moves society inexorably from assisted suicide to euthanasia, from euthanasia for the terminally ill to patients who are chronically ill, from physical suffering to mental suffering, from voluntary requests for euthanasia to killing at the discretion of the physician.⁷⁶

When it comes to assisted suicide (and active euthanasia) the United States is a considerable distance behind (or should one say, ahead of) the Dutch. But developments in this country have not been insignificant. "[I]n only a few years, the debate over euthanasia has moved from acceptance of 'foregoing life-support' to serious consideration of lethal acts."⁷⁷ But we need not focus on this recent development. Back in 1988, some time *before* the legal assault on the distinction between active killing and "letting die" really got underway, Professor Laurence Tribe observed:

72. See Callahan & White, *supra* note 44; Herbert Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure*, 10 ISSUES IN L. & MED. 123, 155 (1994); John Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope*, in EUTHANASIA EXAMINED 261, 269, 275-76 (John Keown ed., 1995). See generally CARLOS F. GOMEZ, *REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS* (1991).

73. Callahan & White, *supra* note 44.

74. *Id.*

75. See Hendin, *supra* note 72, at 123.

76. *Id.* at 124.

77. Albert R. Jonsen, *Physician-Assisted Suicide*, 18 SEATTLE U. L. REV. 459, 467 (1995).

Recent court decisions have rejected many of the distinctions commentators have proposed in earlier discussions about the right to die: not only the distinction between ordinary and extraordinary . . . treatment, but also the distinction between actively hastening death by terminating treatment and passively allowing a person to die of a disease, between withholding and withdrawing life-sustaining treatment, and between the termination of artificial feedings and the termination of other forms of life-sustaining treatment.⁷⁸

If, as has well been said, "the history of our activities and beliefs concerning the ethics of death and dying is a history of lost distinctions of former significance,"⁷⁹ what reason is there to think that history will come to an end when we sanction assisted suicide for the terminally ill? What reason is there to doubt that once we cross the bridge between the termination of life-saving medical treatment and the active intervention of another to bring about death, other lines of demarcation will soon become other "lost distinctions of former significance"?

SUICIDE AND ASSISTED SUICIDE VS. "LETTING DIE"

Professor Sedler has challenged those of us who are opposed to any relaxation of the ban against assisted suicide to defend, "*in terms of constitutional doctrine and precedent*," the distinction between the right to die by refusing life-sustaining medical treatment and the right to die by enlisting the aid of another in committing suicide.⁸⁰ In response, I should like to make several points.

First of all, "the major Anglo-American medical associations vigorously maintain this distinction today"⁸¹ and most courts have had little difficulty grasping its legal significance.⁸² "As these courts have recognized, the fact that the refusal of treatment and assisted suicide may both lead to death does not mean that they implicate identical constitutional concerns."⁸³

78. LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 1364-65 (2d ed. 1988).

79. Thomas Mayo, *Constitutionalizing the "Right to Die"*, 49 MD. L. REV. 103, 144 (1990).

80. See Sedler, *supra* note 2, at 729.

81. Edward J. Larson, *Seeking Compassion in Dying: The Washington State Law Against Assisted Suicide*, 18 SEATTLE U. L. REV. 509, 517 (1995) and medical groups cited therein. See also Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay on Roe, Casey, and the Right to Die*, 44 AM. U. L. REV. 803, 837-38 (1995).

82. See NEW YORK STATE TASK FORCE REPORT, *supra* note 8, and cases collected therein.

83. *Id.* at 71.

In *Cruzan*,⁸⁴ the only "right to die" case ever decided by the United States Supreme Court, the Court "assume[d]" for purposes of the case that a competent person had "a constitutionally protected right" to refuse lifesaving treatment (even nutrition and hydration if artificially delivered).⁸⁵ Nevertheless, the Court seemed to take for granted the constitutionality of laws totally prohibiting assisted suicide. The Court supported its assertion that a state has an undeniable interest in the protection and preservation of human life—even the life of a person in a persistent vegetative state⁸⁶—by noting:

As a general matter, the states—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of states in this country have laws imposing criminal penalties on one who assists another to commit suicide. We do not think a state is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death.⁸⁷

I share the view that this passage appears to endorse laws prohibiting assisted suicide (as well as laws permitting state intervention to prevent suicide).⁸⁸

A recent statement by the Coordinating Council on Life-Sustaining Medical Treatment Decision Making by the Courts typifies the way many courts and commentators have defended the line between "letting die" and actively intervening to promote or to bring about death:

There are significant moral and legal distinctions between letting die (including the use of medications to relieve suffering during the dying process) and killing (assisted suicide/

84. *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990). Although various participants in the debate on death and dying have disagreed about the meaning of some of the language in Chief Justice Rehnquist's majority opinion and Justice O'Connor's concurring opinion in *Cruzan*, the basic facts of the case and its outcome in the United States Supreme Court are worth keeping in mind: Nancy Cruzan was in a persistent vegetative state. Her parents wanted, and claimed they had the right, to terminate the artificial feeding that was keeping their daughter alive. However, Ms. Cruzan had not executed a "living will" or otherwise left clear instructions for ending lifesaving treatment in such circumstances. Because there was no "clear and convincing" evidence of Ms. Cruzan's wishes, the Missouri Supreme Court rebuffed Ms. Cruzan's parents. The United States Supreme Court upheld the state supreme court, *id.* at 282: "In our view, Missouri has permissibly sought to advance [its interest in the preservation of human life] through the adoption of a 'clear and convincing' standard of proof to govern such proceedings."

85. *See id.* at 279.

86. *See id.* at 280.

87. *Id.*

88. *See* Louis Michael Seidman, *Confusion at the Border: Cruzan, "The Right to Die," and the Public/Private Distinction*, 1991 SUP. CT. REV. 47, 53, 62; *see also* Larson, *supra* note 81, at 511-12.

euthanasia). In letting die, the cause of death is seen as the underlying disease process or trauma. In assisted suicide/euthanasia, the cause of death is seen as the inherently lethal action itself.⁸⁹

This "bare bones" statement of the argument becomes much more persuasive, I think, when Daniel Callahan, the director and co-founder of the renowned Hastings Center, explicates and amplifies it:

[T]here must be an underlying fatal pathology if allowing to die is even possible. Killing, by contrast, provides its own fatal pathology. Nothing but the action of the doctor giving the lethal injection is necessary to bring about death.

* * *

[A judgment that further life-extending treatment is futile] . . . is not principally a judgment about a patient's life at all. It is, instead, a judgment about the limits of medical skills in providing further patient benefit. It is a way of saying that, because the limits of those skills have been reached, the patient may be allowed to die.

To call these judgments, and the ensuing omission of treatment, "intending" death distorts what actually happens . . .

[I]f I stop shovelling my driveway in a heavy snowstorm because I cannot keep up with it, am I thereby *intending* a driveway full of snow?

Since death is biologically inevitable sooner or later, not a consequence of our actions but outside of them, we can hardly be said to "intend" death when we admit we can no longer stop it.⁹⁰

As Dr. Callahan suggests, "the refusal of life-sustaining treatment is an integral dimension of medical practice . . ." ⁹¹ Indeed, as Callahan suggests, it is an indispensable part of medical practice. The distinction between "killing" and "letting die" may not be perfectly logical, but, unlike assisted suicide or euthanasia, letting a patient die at some point is a practical condition upon the successful operation of medicine.

A society which *prohibited the refusal* of life-sustaining treatment and enforced such a prohibition with any regularity would not be a pleasant place in which to die (or live). Vast numbers of patients would be "at the mercy of every technological advance."⁹² If people

89. GUIDELINES FOR STATE COURT DECISION MAKING IN LIFE-SUSTAINING MEDICAL TREATMENT CASES 145 (rev. 2d ed. 1993).

90. CALLAHAN, *supra* note 26, at 77-78.

91. See NEW YORK STATE TASK FORCE REPORT, *supra* note 8, at 74.

92. *Id.* at 75. As the Task Force observed:

[I]t is estimated that approximately 70 percent of all hospital and nursing home deaths follow the refusal of some form of medical intervention. A

could decline possibly lifesaving treatment but not discontinue it once initiated, many would probably not seek such treatment in the first place. In short, as one commentator recently put it, "the only way we can offer patients and doctors the chance to prolong life—use life-sustaining treatment—is by also allowing them to decide when to cease such efforts" ⁹³

A prohibition against the refusal of life-sustaining treatment would not only impose a burden on many more people than does a ban on assisted suicide,⁹⁴ but would impose a far more severe burden. Although it closes "[a]n avenue of escape," a ban on assisted suicide does not totally occupy a person's life or make "affirmative use of his body."⁹⁵ However, to deny a person the right to be disconnected from artificial life-support is to force one into

a particular, all-consuming, totally dependent, and indeed rigidly standardized life: the life of one confined to a hospital bed, attached to medical machinery, and tended to by medical professionals. It is a life almost totally occupied. The person's body is, moreover, so far expropriated from his own will, supposing that he seeks to die, that the most elemental acts of existence—such as breathing, digesting, and circulating blood—are forced upon him by an external agency.⁹⁶

prohibition on the refusal of treatment would therefore require the widespread of restraint of patients unwilling to submit to invasive procedures at the end of their lives.

Id. at 74-75 (footnote omitted).

93. Giles R. Scofield, *Exposing Some Myths About Physician-Assisted Suicide*, 18 SEATTLE U. L. REV. 473, 481 (1995).

94. [T]o the extent that laws prohibiting assisted suicide and euthanasia impose a burden, they do so only for individuals who make an informed, competent choice to have their lives artificially shortened, and who cannot do so without another person's aid. As studies have confirmed, very few individuals fall into this group, particularly if appropriate pain relief and supportive care are provided.

NEW YORK STATE TASK FORCE REPORT, *supra* note 8, at 72.

95. See Jed Rubenfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 795 (1989). Actually, Professor Rubenfeld is writing about suicide, not assisted suicide. But there no longer are any criminal laws in this country prohibiting suicide or attempted suicide. A ban on *assisted* suicide only imposes a burden on those individuals who want to end their lives *and* cannot do so without another's aid. Evidently very few people fall into this group. See discussion *supra* note 94.

96. Rubenfeld, *supra* note 95, at 795. *Cruzan*, 497 U.S. at 287-88: (O'Connor, J., concurring) (citation omitted):

As the Court notes, the liberty interest in refusing medical treatment flows from decisions involving the State's invasions into the body. Because our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause. . . . The State's imposition of medical treatment on an unwilling

I share the view of the New York State Task Force on Life and the Law that it is "this right against intrusion—not a general right to control the timing and manner of death—that forms the basis of the constitutional right to refuse life-sustaining treatment."⁹⁷

Moreover, as Professor Seth Kreimer has observed, so far as the dangers of mistake or abuse are concerned, "a right to refuse treatment puts at risk only the lives of those who would die without treatment," but "the approval of active euthanasia or assisted suicide would extend the risk to the entire population."⁹⁸ Adds Kreimer:

Particularly with the emergence of cost controls and managed care in the United States, the danger of tempting health care providers to persuade chronic patients to minimize costs by ending it all painlessly is no fantasy. The quantitative distinction between some and all can be a legitimate predicate for the qualitative distinction between permission and prohibition.⁹⁹

I realize that many do not consider the arguments made in defense of the distinction between suicide/assisted suicide and the refusal of life-saving treatment completely satisfying. But the distinction between active killing or active intervention to bring about death and "letting die" has more to commend it than mere logic.

For one thing, the distinction represents an historical and pragmatic compromise between the desire to let seriously ill people carry out their wishes to end it all and the felt need to protect the weak and the vulnerable. As Dean (now Judge) Guido Calabresi has observed, when we must make tragic choices—choices that confront us when fundamental beliefs clash—we seek solutions that "permit us to assert

competent adult necessarily involves some form of restraint and intrusion. A seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures or other medical interventions. Such forced treatment may burden that individual's liberty interests as much as any state coercion.

97. NEW YORK STATE TASK FORCE REPORT, *supra* note 8, at 71 (footnote omitted); see also Scofield, *supra* note 93, at 478 (footnote omitted):

The right not to be touched against one's wishes is the value that underlies the principle of self-determination protected under the law in the name of the "right to die." In the world of philosophy and ethics, this has meant respecting a patient's negative right of noninterference—the right to be let alone. Respecting that right requires forbearance; we must either not initiate treatment or withdraw a treatment we have initiated. Whichever it is, we are to back off.

Where the "right-to-die" consists of physician-assisted suicide, respecting this right requires doctors to assist, not desist. Medical forbearance simply will not produce the desired result.

98. Kreimer, *supra* note 81, at 841.

99. *Id.*

that we are cleaving to both beliefs in conflict."¹⁰⁰ As good an example as any of what Judge Calabresi had described is the way we have dealt with the law and ethics of death and dying.

On the one hand, we want to respect patients' wishes, relieve suffering, and put an end to seemingly futile medical treatment. Hence we allow patients to refuse life-sustaining treatment. On the other hand, we want to affirm the supreme value of life and to maintain the salutary principle that the law protects all human life, no matter how poor its quality. Hence the ban against assisted suicide and active voluntary euthanasia.

I venture to say that one of the purposes of the distinction between the termination of life support and assisted suicide (or active voluntary euthanasia)—or at least one of its principal effects—is to have it both ways. The two sets of values are in conflict, or at least in great tension. Nevertheless, until now at any rate, we have tried to *honor both* sets.

I realize that drawing a line between assisted suicide (or active voluntary euthanasia) and "letting die" will not please every logician or philosopher. But what line will?

This brings us to another factor at work in this area—a factor that I think accounts for a good deal of the support for maintaining the "historic divide" between "active killing" and "letting die."¹⁰¹ Unless we carry the principle of "self-determination" or "personal autonomy" or "control of one's own destiny" to its ultimate logic—assisted suicide (and active euthanasia) by any competent individual who firmly requests it for any reason *the individual* deems appropriate—we have to draw a line *somewhere* along the way. But *where*? I submit that *no* intermediate line, certainly not the one Sedler and his colleagues suggest, would be any more defensible than the one we have now. So why cross the line we have now?

I suspect that few, if any, have ever been in a better position than Wayne County Circuit Judge Richard Kaufman to appreciate the difficulties involved in drawing what I have called an "intermediate line." In late 1993, Judge Kaufman became the first American judge ever to hold squarely that there is a constitutional right to assisted suicide (under certain conditions).¹⁰² Although his decision was ultimately

100. CALABRESI, *supra* note 68, at 88; *cf. id.* at 87-91. See also GUIDO CALABRESI, A COMMON LAW FOR THE AGE OF STATUTES 172-77 (1982).

101. *Cf.* Albert W. Alschuler, *Reflection, in ACTIVE EUTHANASIA, RELIGION, AND THE PUBLIC DEBATE* 105, 108 (Martin Marty & Ron Hamel eds., 1991) (a publication of The Park Ridge Center).

102. *People v. Kevorkian*, No. 93-11482, 1993 WL 603212 (Mich. Cir. Ct. Wayne County Dec. 13, 1993). Judge Kaufman's opinion is discussed at considerable length in Kamisar, *The Last Bridge to Active Voluntary Euthanasia*, *supra* note 48, at 240-44.

Professor Sedler and his ACLU colleagues were not directly involved in this case. The ACLU and Dr. Jack Kevorkian have kept at some considerable distance from each other.

overturned,¹⁰³ even his critics (and I am one of them) concede that Judge Kaufman wrote a long, thoughtful, well-documented opinion.

I deem it noteworthy that Judge Kaufman drew a line *neither* (a) between terminally ill people seeking to die by suicide and others wishing to do so *nor* (b) between those experiencing severe "pain and suffering" and others whose pain and suffering was, or could be, brought under control. Rather, Judge Kaufman drew the "intermediate line" between the presence and absence of an "objective medical condition" that was "extremely unlikely to improve."¹⁰⁴

If an individual's quality of life was significantly impaired by such a medical condition, even though it was not a life-threatening condition, the individual could exercise the newly established constitutional right. But if an individual's quality of life was significantly diminished for any other reason (e.g., disgrace, financial ruin, the death of a spouse), she could not invoke the constitutional right—no matter how competent she was or firm her desire to die.¹⁰⁵

Although there was some confusion about this, the line Judge Kaufman wound up drawing was *not* a line between "rational" and "irrational" suicide. Rather, it was a line between *one category* of "rational" suicide—where the would-be suicide's life was significantly impaired by an irreversible medical condition—and *other categories* of "rational" suicide.

Judge Kaufman did not draw the line simply between rational and irrational suicide because he feared that "any form of *rational* suicide that did not include the presence of an objective medical condition would be *too close* to irrational suicide."¹⁰⁶ If constitutional protection were extended to *all* persons who harbored a rational wish to die, he told us, "the possibility that irrational suicide would increase is too great."¹⁰⁷ Therefore, according to Judge Kaufman, a state not only has the power to prohibit all classes of "irrational" suicide and assisted suicide, but some classes of "rational" suicide and assisted suicide as well (those where one's quality of life has not been impaired by an objective medical condition).

Judge Kaufman made a valiant effort to find a sensible legal solution to an excruciatingly hard problem. But if a judge can deny constitutional protection to *some* forms of "rational" assisted suicide out of

103. In May of 1994 a two to one majority of the Michigan Court of Appeals ruled that there was no constitutional right to assisted suicide, *Hobbins v. Attorney Gen.*, 518 N.W.2d 487 (Mich. Ct. App. 1994), and seven months later a five to two majority of the Michigan Supreme Court announced its agreement with the court of appeals on this point. *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994) (consolidated with *Hobbins*), *cert. denied*, 115 S. Ct. 714 (1995).

104. *Kevorkian*, No. 93-11482, 1993 WL 603212, at *18-19.

105. *See id.* at *19.

106. *Id.* at *18 (emphasis added).

107. *Id.*

concern that unless this is done "irrational" assisted suicide might get out of hand, why can't a legislature prohibit *all* forms of "rational" assisted suicide on the same grounds?

After all, geriatric psychiatrists (who work with suicidal people every day) and suicidologists (who perform "psychological autopsies" of people who commit suicide) tell us that a suicide rarely occurs in the absence of a major psychiatric disorder, and that this observation holds for suicides among the elderly.¹⁰⁸ Moreover, these experts underscore the inability of depressed persons to recognize the severity of their own symptoms and the failure of primary physicians to detect major depression, especially in elderly patients.¹⁰⁹

As one authority has observed, we encourage suicide among the elderly "by our neglect and indifference."¹¹⁰ As another commentator has put it, "[s]uicidal persons are succumbing to what they experience as an overpowering and unrelenting coercion in their environment to cease living."¹¹¹ Is it not fair to assume that these pressures will intensify in a society that sanctions assisted suicide (and thereby suicide as well)? Is it not fair to assume that once assisted suicide is a lawful alternative and people are "doing it," and feel free to talk about it, more people, especially the sick, the old and the vulnerable, will see this route as a tempting way to spare both oneself and one's family and friends the burden of serious illness and/or advanced age?¹¹²

THE "ABORTION CASES": HOW EXPANSIVE IS THE CONCEPT OF PRIVACY?

Professor Sedler and his allies find support for their views in the Supreme Court's abortion cases.¹¹³ In *Roe v. Wade*,¹¹⁴ the Court informed us that a "right of privacy," which had earlier been invoked to strike down restrictions on the use and distribution of contracep-

108. See James H. Brown, et al., *Is It Normal for Terminally Ill Patients to Desire Death?*, 143 AM. J. PSYCHIATRY 208, 210 (1986); Yeates Conwell & Eric D. Caine, *Rational Suicide and the Right to Die*, 325 NEW ENG. J. MED. 1100, 1101 (1991); Herbert Hendin & Gerald Klerman, *Physician-Assisted Suicide: The Dangers of Legalization*, 150 AM. J. PSYCHIATRY 143 (1993); Roberta Richardson, et al., *Coping with the Suicidal Elderly: A Physician's Guide*, GERIATRICS, Sept. 1989, at 43-44.

109. See David C. Clark, "Rational" Suicide and People with Terminal Conditions or Disabilities, 8 ISSUES IN L. & MED. 147, 155, (1992); Conwell & Caine, *supra* note 108, at 1101.

110. GEORGE H. COLT, *THE ENIGMA OF SUICIDE* 394 (1991).

111. *Id.* at 342 (quoting MENNO BOLDT, *THE RIGHT TO SUICIDE* (1985) (Suicide Information and Education Centre Current Awareness Bulletin, 1 (2), at 1)).

112. For a discussion of "circumstantial" and "societal" manipulation in the context of suicide, see M. Pabst Battin, *Manipulated Suicide*, in *SUICIDE: THE PHILOSOPHICAL ISSUES* 169 (M. Pabst Battin & David J. Mayo eds., 1980).

113. See Sedler, *supra* note 2, at 728-733. See also Sedler, *supra* note 35, at 23-24.

114. 410 U.S. 113 (1973).

tives,¹¹⁵ "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy."¹¹⁶ The Court cleared the way for its ultimate holding by rejecting the state's argument that "a fetus is a person" within the meaning of the Constitution—"the word 'person', as used in the Fourteenth Amendment, does not include the unborn."¹¹⁷ Although *Roe* did not involve the termination of a human life (so far as the Court was concerned), Sedler and others have read the case and its progeny very broadly to support a "right" or "liberty," under certain circumstances, to enlist the assistance of others in committing suicide.¹¹⁸

I agree with Professor Sedler that the constitutional answer to the question he and his colleagues pose "must be found in applicable Supreme Court doctrine and precedent."¹¹⁹ But *what* are the relevant precedents? (Why, for example, does Sedler totally ignore *Bowers v. Hardwick*,¹²⁰ a case which, so long as it remains on the books, greatly reduces *Roe*'s potential for expansion?) And *how* should we characterize the applicable doctrine?

"The laws struck down under the rubric of privacy have had a peculiar tendency to gravitate around sexuality"¹²¹—"not 'sex' as such, of course, but sexuality in the broad sense of that term: the network of decisions and conduct relating to the conditions under

115. See *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Eisenstadt v. Baird*, 405 U.S. 438 (1972).

116. *Roe*, 410 U.S. at 152-53. But the right is not absolute. *Id.* at 162-66. As a general proposition, after fetal viability the state may proscribe abortion. *Id.* at 164-65. As a general matter, before viability the state may not. *Id.* at 163-64. But "the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman . . ." *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2804 (1992) (emphasis added).

Suppose, because of a pregnant woman's special disability or particular illness, an abortion before fetal viability can only be performed at great risk to her life. Suppose, further, that the woman still wants an abortion. I take it that under such circumstances the state could prevent the abortion from being performed despite the woman's wishes.

If so, if a state can override a woman's choice when the abortion she desires would jeopardize her life, does it not follow that, consistently with the abortion cases, a state can ban a so-called medical procedure intended to and designed to end a person's life? Does it not follow, too, that a state can block the active intervention of a physician trying to promote or to bring about a patient's death? See Marc Spindelman, *Roe vs. Wade Recognizes No 'Right to Die'*, DETROIT NEWS, Oct. 16, 1994, at 3B.

117. *Roe*, 410 U.S. at 157-58.

118. See *supra* note 113 and accompanying text.

119. Sedler, *supra* note 2, at 728.

120. 478 U.S. 186 (1986) (upholding prohibition against consensual sodomy as applied to homosexuals, even though the activity took place in private).

121. Rubinfeld, *supra* note 95, at 738.

which sex is permissible, the social institutions surrounding sexual relationships, and the procreative consequences of sex."¹²²

Although the plaintiffs in *Roe* and its companion case¹²³ did not even challenge the abortion restrictions as sex discriminatory, a growing number of commentators, including Judge (now Justice) Ruth Bader Ginsburg,¹²⁴ have maintained that the best argument for the right to abortion is based on principles of "sex equality," not "due process" or "privacy."¹²⁵ As then Judge Ginsburg noted (in a lecture delivered shortly before her nomination to the United States Supreme Court), in *Planned Parenthood v. Casey*,¹²⁶ which reaffirmed *Roe*, the majority "added an important strand to the Court's opinions on abortion"—it "acknowledged the intimate connection between a woman's 'ability to control [her] reproductive li[fe]' and her 'ability [to] participate equally in the economic and social life of the Nation.'"¹²⁷

"Laws restricting abortion so dramatically shape the lives of women, and only of women," Professor Laurence Tribe has observed,

122. *Id.* at 744. See also RICHARD A. POSNER, *SEX AND REASON* 325 (1992):

In a series of decisions between 1965 and 1977 [*Griswold v. Connecticut*, 381 U.S. 479 (1965); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Roe v. Wade*, 410 U.S. 113 (1973); and *Carey v. Population Services International*, 431 U.S. 678 (1977)], the Supreme Court created a constitutional right of sexual or reproductive autonomy, which it called privacy.

All four cases, adds Judge Posner, *id.* at 343, can be "viewed as decisions motivated by a concern with the burdens of unwanted pregnancy, a concern that resonates with the women's movement and thus connects with the Court's decisions invalidating sexually discriminatory legislation under the equal protection clause"

123. *Doe v. Bolton*, 410 U.S. 179 (1973).

124. See Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. REV. 1185, 1199-1202 (1992); Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C. L. REV. 375, 382, 386 (1985).

125. See CALABRESI, *supra* note 68, at 99-102; CASS R. SUNSTEIN, *THE PARTIAL CONSTITUTION* 272-85 (1993); TRIBE, *supra* note 78, at 1353-55; Kenneth L. Karst, *Foreword: Equal Citizenship Under the Fourteenth Amendment*, 91 HARV. L. REV. 1, 57-59 (1977); Kreimer, *supra* note 81, at 849; Catharine A. MacKinnon, *Reflections on Sex Equality Under Law*, 100 YALE L.J. 1281, 1319 (1991); Frances Olsen, *Unraveling Compromise*, 103 HARV. L. REV. 105, 117-26 (1989); Giles R. Scofield, *Rethinking Roe*, 8 TRENDS IN HEALTH CARE, L. & ETHICS 17, 19-20 (Summer, 1993); Reva Siegel, *Reasoning From the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 350-80 (1992); David A. Strauss, *Abortion, Toleration and Moral Uncertainty*, 1992 SUP. CT. REV. 1, 18-22. See also POSNER, *supra* note 122, at 339-40 (recognizing that "focus" of *Roe*'s legal defenders has "shifted to the equal protection clause," but questioning the adequacy of this approach); cf. Donald H. Regan, *Rewriting Roe v. Wade*, 77 MICH. L. REV. 1569, 1618-42 (1979) (contending that a pregnant woman is a "potential Samaritan" vis-a-vis her fetus, and should not be treated differently from other potential Samaritans).

126. 505 U.S. 833 (1992).

127. Ginsburg, *Speaking in a Judicial Voice*, *supra* note 124, at 1199 (quoting *Casey*, 505 U.S. at 856). On this point, the controlling Justices in *Casey* (O'Connor, Kennedy and Souter, JJ.) spoke for the Court. See also 505 U.S. at 928 (Blackmun, J., concurring): "[A] State's restrictions on a woman's right to terminate her pregnancy also implicate constitutional guarantees of gender equality."

"that their denial of equality hardly needs elaboration."¹²⁸ Continues Tribe:

While men retain the right to sexual and reproductive autonomy, restrictions on abortion deny that autonomy to women. Laws restricting access to abortion thereby place a real and substantial burden on women's ability to participate in society as equals. Even a woman who is not pregnant is inevitably affected by her knowledge of the power relationships created by a ban on abortion.¹²⁹

The more the right to abortion is grounded on "sexual equality," or the more *Roe* is justified on that basis, the less comfort that right offers proponents of a constitutional right to assisted suicide. But even those who continue to view the right to abortion as based on "privacy" or "personhood" must take into account how the scope and meaning of these rather abstract concepts are affected by the decision in *Bowers v. Hardwick*.¹³⁰

I would not have joined Justice White's opinion for the Court in *Hardwick*. I agree with former Solicitor General Charles Fried that the opinion White wrote upholding the constitutionality of a state law criminalizing consensual sodomy, as applied to homosexuals, is "stunningly harsh and dismissive."¹³¹ But Justice White spoke for five members of the Court. Any discussion of the breadth and potential for expansion of such concepts as "privacy" and "personhood" which ignores *Hardwick* (as does Professor Sedler, and as did Judge Rothstein when she invalidated an anti-assisted suicide law)¹³² is seriously incomplete.

"The Court is most vulnerable and comes nearest to illegitimacy," observed the *Hardwick* Court, per Justice White, "when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution."¹³³ More specifically, the Court's prior "privacy" cases had recognized three categories of protected activity—marriage, procreation, and family relationships—but "[n]o connection" between "homosexual activity" and any of these categories was demonstrated.¹³⁴

As Professor Jed Rubenfeld has observed:

128. LAURENCE H. TRIBE, *ABORTION: THE CLASH OF ABSOLUTES* 105 (1990).

129. *Id.*

130. *See* 478 U.S. at 186.

131. CHARLES FRIED, *ORDER AND LAW* 82 (1991). For powerful criticism of *Hardwick*, see TRIBE, *supra* note 78, at 1421-35. As Professor Tribe acknowledges, he argued the case in the Supreme Court for the losing party.

132. *See supra* note 28 and accompanying text.

133. 478 U.S. at 194.

134. *Id.* at 191.

Justice White neither sought nor found any unifying principle underlying his three categories. It was as if the Court had said, "We in the majority barely understand why even these three areas are constitutionally protected; we simply acknowledge them and note that they are not involved here." The device of compartmentalizing precedent is an old jurisprudential strategy for limiting unruly doctrines. The effect here is that, after *Hardwick*, we know that the right to privacy protects some aspects of marriage, procreation, and child-rearing, but we do not know why. By identifying three disparate applications ungrounded by any unifying principle, the majority effectively severed the roots of the privacy doctrine, leaving only the branches . . . ¹³⁵

I do not deny that a colorable argument may be made that the "right of privacy" invoked in *Roe* includes the "right" or "liberty" of a person to choose whether to continue to live until death comes naturally or to hasten death by obtaining the active intervention of another. But a *much stronger* argument may be made, I think, that the "right of privacy" encompasses the autonomy of sexual activity and relationships.

As Justice Blackmun wrote in *Hardwick*, "sexual intimacy is 'a sensitive, key relationship of human existence, central to . . . the development of human personality'"; "individuals define themselves in a significant way through their intimate sexual relationships with others" and "much of the richness of a relationship will come from the freedom an individual has to *choose* the form and nature of these intensely personal bonds."¹³⁶ But Justice Blackmun wrote in dissent.

I share Justice Blackmun's view that before it can punish its people for their actions, a state "must do more than assert that the choice they have made is an 'abominable crime not fit to be named among Christians.'"¹³⁷ I agree, too, with another *Hardwick* dissenter, Justice Stevens, that "the fact that the governing majority in a State has traditionally viewed a particular practice as immoral is not a sufficient reason for upholding a law prohibiting the practice . . ."¹³⁸ However, as the recent report of the New York State Force on Life and the Law well demonstrates, any state that prohibits assisted suicide can advance justifications for its legislation that go well beyond the law's conformity to religious doctrine or "morality."¹³⁹

135. Rubinfeld, *supra* note 95, at 748-49. See also POSNER, *supra* note 122, at 341 (asserting that *Hardwick* "froze the constitutional right of privacy").

136. 478 U.S. at 205 (Blackmun J., joined by Brennan, Marshall and Stevens, JJ., dissenting).

137. *Id.* at 199-200.

138. 478 U.S. at 216 (Stevens, J., joined by Brennan and Marshall, JJ., dissenting).

139. Among the reasons the Task Force gave for resisting even a very limited form of physician-assisted suicide (or active voluntary euthanasia) were:

In *Planned Parenthood v. Casey*,¹⁴⁰ in the course of reaffirming *Roe*, the Court spoke at one point about "the right to define one's own concept of existence" and one's concept of "the mystery of human life" as being "at the heart of liberty."¹⁴¹ As did Judge Rothstein in *Compassion in Dying*,¹⁴² Sedler finds much solace in this capacious language.¹⁴³ The language constitutes the last two sentences of a long paragraph. I would like to quote the entire paragraph, including the first four sentences:

Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. Our cases recognize "the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." Our precedents "have respected the private realm of family life which the state cannot enter." *These matters*, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty

[1] Illness is a quintessential state of vulnerability [and p]atients bring this vulnerability to their relationship with physicians As with other "treatments" judgments about when and for whom assisted suicide and euthanasia are provided would be managed principally by physicians, not their patients.

NEW YORK STATE TASK FORCE REPORT, *supra* note 8, at 121.

[2] In light of the pervasive failure of our health care system to treat pain and diagnose and treat depression, legalizing assisted suicide and euthanasia would be profoundly dangerous for many individuals who are ill and vulnerable, [especially] for those who are elderly, poor, socially disadvantaged, or without access to good medical care.

Id. at ix.

[3] Out of benevolence or from sheer frustration or exhaustion, [relatives] may suggest or encourage the patient to accept assisted suicide or euthanasia [and] [m]otivated by a sense of guilt or abandonment, many patients will feel that they have no choice once the option is presented. Indeed, if [these options] are widely available, patients may feel obligated to consider [them] to alleviate the burden their illness and continued life imposes on those closest to them.

Id. at 124. And finally,

[4] [A]ssisted suicide and euthanasia are closely linked; as [shown by the experience in the Netherlands, where a lethal injection is preferred by both doctors and patients,] once assisted suicide is embraced, euthanasia will seem only a neater and simpler option to doctors and their patients.

Id. at 145 (footnote omitted). *See also supra* notes 14-15 and accompanying quotations from the NEW YORK STATE TASK FORCE REPORT.

140. 505 U.S. 833 (1992).

141. *Id.* at 851.

142. *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1459-61 (W.D. Wash. 1994), *rev'd*, 49 F.3d 586 (9th Cir. 1995). The Chief Judge and ten other members of the Ninth Circuit are scheduled to rehear this case *en banc*. 62 F.3d 299 (1995).

143. *See Sedler, supra* note 2, at 728.

protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.¹⁴⁴

This paragraph does contain some sweeping language. But I think such language can plausibly be read as explaining why "*these matters*"—"personal decisions relating to marriage, procreation, contraception" and "family relationships" or, more summarily, "the private realm of family life"—*have been given* constitutional protection.

Viewed in isolation, the language about "defin[ing] one's own concept of existence" and "of the mystery of human life" does seem breathtaking. Literally, it *would* cover the right of terminally ill people to enlist the assistance of another in committing suicide. But literally it would also cover the right of *any* competent person—physically ill *or not*—to enlist the aid of another in suicide.¹⁴⁵

Professor Sedler maintains that the right to define one's concept of existence (and to make basic decisions about one's bodily integrity) "surely must include" the right of terminally ill persons to obtain assistance in ending their lives,¹⁴⁶ *but not* the right of anybody else to do so.¹⁴⁷ Why not?

I understand how one can read the passage quoted above narrowly (limiting it to reproductive rights and related matters) or read it broadly (including death and dying). But I fail to see how one can read it the way Sedler does.

If, as Sedler seems to say, the right to "define one's concept of existence" includes the right to end one's existence with the active assistance of another, and if, as he also seems to say, the right to "define one's own concept . . . of the mystery of human life" includes the right to end one's interest in life and its mystery with the active assistance of another, why are these rights limited to the terminally ill? Either the language quoted above refers only to personal decisions relating to marriage, procreation, contraception, child rearing and the like, or it refers to all that plus personal decisions relating to suicide and suicide assistance. If the latter, why doesn't *everybody* have the

144. *Casey*, 505 U.S. at 851 (citations omitted; second emphasis added.)

145. As Judge John Noonan observed for a two to one majority in *Compassion in Dying*:

If at the heart of the liberty protected by the Fourteenth Amendment is this uncurtailable ability to believe and to act on one's deepest beliefs about life, the right to suicide and the right to assistance in suicide are the prerogative of at least every sane adult.

49 F.3d 591.

146. See Sedler, *supra* note 2, at 728.

147. *Id.* at 727.

right to define his concept of existence or his concept of the mystery of life?

Why are these awesome rights denied to the great majority of us because our lives are of "indefinite duration"?¹⁴⁸ Why, if people so wish, can't they *change that*? Why, if they so desire, can't people bring a life of "indefinite duration" to a definite and abrupt close? Is the choice *whether* to end one's life and *how* to do so "central to the liberty protected by the Fourteenth Amendment"¹⁴⁹ or is it not?

A reading of "the right to define one's own concept of existence" language broad enough to cover assisted suicide would be broad enough to cover a great many other things. It would surely cover the autonomy of sexual activity and relationships, and it would do so more easily than it would embrace assisted suicide. Moreover, the connection between "homosexual activity" and the categories of activity already protected by the "privacy" cases seems much closer than the relationship between assisted suicide and categories of activity already protected. So far as I am aware, however, nobody has suggested that *Casey* overrules *Bowers v. Hardwick*.

As a panel of the Ninth Circuit observed, in reversing a federal district judge who had relied heavily on the same spacious language that Sedler and his colleagues do:

The language taken from *Casey*, on which the district court pitched its principal argument, should not be removed from the context in which it was uttered. Any reader of judicial opinions knows they often attempt a generality of expression and a sententiousness of phrase that extend far beyond the problem addressed. . . . To take [a few lines] out of an opinion over thirty pages in length dealing with the highly charged subject of abortion and to find these [few lines] "almost prescriptive" in ruling on a statute proscribing the promotion of suicide is to make an enormous leap, to do violence to the context, and to ignore the differences between the regulation of reproduction and the prevention of the promotion of killing a patient at his or her request.¹⁵⁰

148. See *id.* at 726-27:

[A]s to assisted suicide, of course the state can constitutionally prohibit assisting a suicide in the ordinary sense of the term—that is, by providing assistance in ending a life that is otherwise of indefinite duration. . . . [T]he principle [that the government has the power to protect us from ourselves] would be relied on by the courts to sustain a ban on assisted suicide in the ordinary sense of the term.

149. See *supra* note 144 and accompanying quote from *Casey*.

150. *Compassion in Dying*, 49 F.3d at 590 (two to one majority per Noonan, J.). As indicated earlier, the Ninth Circuit is scheduled to rehear this case *en banc*. 62 F.3d 299 (1995).

I do not think we should read too much into the soaring language found in one small segment of a long opinion. Although it "pointedly reaffirmed the 'essential holding' of *Roe v. Wade* that abortions prior to fetal viability may not be criminalized,"¹⁵¹ *Casey* "notably retreats from *Roe*."¹⁵² By upholding several provisions of a state act that imposed restrictions on reproductive freedom that "could not have survived strict adherence to *Roe*,"¹⁵³ the Court "once again invited state legislatures to regulate and sharply restrict access to legal abortions."¹⁵⁴

Moreover, in reaffirming *Roe*, the *Casey* majority relied heavily on the rule of *stare decisis*. Absent "the most compelling reason to reexamine a watershed decision," the majority told us, to overrule *Roe* "under fire" would "subvert the Court's legitimacy beyond any serious question."¹⁵⁵

Finally, the three controlling jurists, Justices O'Connor, Kennedy and Souter, (none of whom had been on the Court when *Roe* was decided) made an extraordinary statement:

We do not need to say whether each of us, had we been Members of the Court [when *Roe* was decided], would have concluded, as the *Roe* Court did, that [the weight of the State's interest in protecting the potentiality of life] is insufficient to justify a ban on abortions prior to viability. . . . The matter is not before us in the first instance, and coming as it does after nearly 20 years of litigation in *Roe*'s wake we are satisfied that the immediate question is not the soundness of *Roe*'s resolution of the issue, but the precedential force that must be accorded to its holding.¹⁵⁶

All things considered, I believe the Court that reaffirmed *Roe* in 1992 was bent on bringing an old constitutional war to an end—not preparing to fight a new one.

A FINAL THOUGHT

"[E]very person in Holland has free access to health care" and thus "concern about America's 34 million uninsured citizens—several times greater than the entire population of Holland—does not come into the picture."¹⁵⁷ Nor do "the feelings, pressures, and fears of mil-

151. Kathleen Sullivan, *Foreword: The Justices of Rules and Standards*, 106 HARV. L. REV. 22, 27 (1992).

152. Ginsburg, *Speaking in a Judicial Voice*, *supra* note 124, at 1208.

153. *Id.* at 1199.

154. *The Supreme Court, 1991 Term*, 106 HARV. L. REV. 19, 201 (1992).

155. 505 U.S. at 851; *see also id.* at 868-69.

156. *Id.* at 871.

157. AHRONHEIM & WEBER, *supra* note 21, at 90-91.

lions of other Americans who may not have adequate coverage to pay for relevant services.”¹⁵⁸

I agree with Professor Giles Scofield that —

*The moral issue of our day is not whether to enable or prevent a few individuals’ dying in the comfort of their home in the presence of their private physicians. The moral issue of our day is whether to do something about our immoral system of care, in which treatment is dispensed according to a principle best characterized as that of economic apartheid.*¹⁵⁹

As my former colleague, Robert Burt, recently observed, at a time when many millions of Americans lack adequate health care and Congress has refused to do much about it, “it would be ironic if the judiciary selected physician-assisted suicide as the one health care right that deserves constitutional status.”¹⁶⁰

158. *Id.* at 91.

159. Scofield, *supra* note 93, at 491.

160. Robert A. Burt, *Death Made Too Easy*, N.Y. TIMES, Nov. 16, 1994, at A15.